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POSTERIOR DISPLACEMENTS OF THE UTERUS.

Remarks upon Pathology and Treatment.

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The subject of displacements of the uterus has probably received more attention than any other topic of interest to the gynecologist; yet there is much uncertainty in reference to the pathology of such cases, and not a little error in the recognized treatment of them. It occurs to the writer that very much of the doubt in reference to the treatment of these lesions, arises from a refusal on the part of the profession to accept clearly proven and demonstrable facts.

There has been very much temporizing, and the climax of absurdity has been reached in the effort to treat the various displacements of the uterus by means of pessaries without regard to the cause. It has frequently occurred that patients have gone the round of physicians, including some specialists, vainly expecting relief from some vaginal support, which the attendant informed them might confidently be expected. It has doubtless been the hope that some accident might cure the patient during the treatment, and that this does occasionally occur is true. I can but judge by observation that very much of the routine practice of inserting pessaries, is based upon a misunderstanding of the causes and complications attending cases of displacement. It is often a means of satisfying the mind of the patient that her disease is having the proper treatment, while the real fact is reserved that cures are indeed very rare from pessary-wearing alone. Indeed, it appeared at one time in the history of gynecology, that the road to fame might lie in the invention of a pessary, so zealously were they forced upon the attention of the profession. It is confidently

to be hoped that, with the clearer light of the present pathology, rational methods of treatment may prevail.

After years of experience with the theoretical treatment of these displacements, we can appreciate the truth and force of the statement of Bernutz: "It has been my aim to prove that deviations of the uterus, when simple, with the exception of prolapsus and procidentia, do not cause any functional disturbance; but when complicated with old pelvi-peritonitis or uterine catarrh, or congestion, the faulty position and the abnormal mobility are a source of pain, and demand treatment." (*Sydenham Transactions, etc.*). These views should, for the most part, guide us to-day; for it would not be far wrong to say that those who are in the best position to know the truth or falsity of the remark, do not hesitate to endorse the great French writer.

In opening up the abdomen for Battey's or Tait's reasons, it has been found that the parametritis or cellulitis suspected, is generally pelvic peritonitis or its results,—adhesions of the Fallopian tube and ovary to any adjoining peritoneal surface. The uterus, in nearly all these cases, is fixed in its position by these adhesions affecting its ligamentary, chiefly peritoneal, supports, and is often found displaced backward in version or flexion.

It is not, therefore, surprising to find men having to do pelvic surgery who eschew pessaries.

I am confident that in this year of 1890, pathological conditions should be so well understood as not to suggest a pessary when there are adhesions holding down a retroflexed uterus. The quotation from Bernutz is important from another point—that in reference to the symptoms caused by these displacements. When we take into consideration the vast number of displaced uteri found and treated by the profession, and add to these the additional number not known but surely existing, we can form some idea of the innocuousness of any mere displacement which is without the symptomatic suffering. The truth can never be ascertained as to the frequency of displacements, for we only know of those giving rise to symptoms. We are daily learning that a displaced uterus causes pain, discomfort, or reflexed symptoms, just so much as it displaces, distorts, or involves other organs and tissues adjacent to it. Therefore, granted a displacement backward, what are its causes?

First, intrapelvic disease influencing the uterine supports.

Second, changes in the body of the uterus itself.

It is probable that the first heading would include the second, if such changes are a result of intrapelvic lesions, which indeed is generally the case. The cause of retro-displacement is in by far the greatest number of cases due to intrapelvic inflammation. The result of such inflammation in the form of adhesions between peritoneal surfaces, and influencing the position and length of the various ligaments, constitutes the lesion which at once indicates with how much difficulty a cure may be accomplished by any vaginal support. In addition to such traction as may be exerted by inflammatory changes within the pelvis, there must be mentioned the growth of tumors, and other changes in the uterus itself, or in adjacent structures, yet influencing its position.

The second class is intended to apply to those cases where the uterus may be displaced by reason of organic change in its muscularity, as from fatty degeneration, subinvolution, etc., yet not due to those causes before mentioned, such as fibroid or other tumors.

TREATMENT.—Displacements of the uterus backward involve two very important considerations, which the practical gynecologist must at once determine when investigating such cases.

First, What is the size of the organ?

Seoond, Is it fixed or movable, *i. e.*, can it be easily replaced?

The question is thus simplified by removing all the accumulated verbiage surrounding it. In this connection must come the inquiry, How much is the patient's health influenced by the malposition? This question is all-important, for no absolute relation of cause and effect can be formulated for these cases of disease. Very many women carry their wombs in the third degree of the prolapse, yet without great suffering. Others appear to suffer greatly from the slightest supposed abnormal position.

To return to the treatment of mild cases or those without great pain, fixation, or other evidence of intrapelvic disease, it appears that very much of the treatment of these slight retro-displacements is entirely unnecessary. In looking over my own experience, I do not find so many cases of malposition requiring vaginal support, as when, earlier in practice, one was taught that very much of the backache and other suffering in women was due to these displacements. I can only rely upon the evidence furnished by my medical

friends and fellow gynecologists, to support me in this opinion, that the pessary is slowly sinking into desuetude. I am fully convinced that at no distant day, medical men generally will place the pessary where it belongs, and not use it without positive indications.

The symptoms of dislocated uteri are the symptoms in a large number of cases of *nerve tire*, and demand systematic electrical, medicinal, and hygienic treatment. That the use of a pessary serves to calm the fears of a nervous woman, is no excuse for continuing its use when the flexion, if present, cannot be cured by it, and perhaps other and more important treatment is being neglected. Several years ago, a married lady, aged forty-eight years, who had been suffering for some months with insomnia, was sent to me for examination. Her physician suspected a uterine cause, and I found it, as I supposed, in a retroflexed uterus, which had probably caused her sterility, for she had no children. She was in good flesh, and there appearing no other cause for her sleeplessness, I inserted a Hodge pessary to sustain (?) the fundus uteri. She was at once greatly benefited, but in a short time her insomnia returned, and she sought relief at a well-known water cure establishment. The pessary was removed, and the excellent hygienic treatment served to cure the insomnia. After her return, she allowed her curiosity to get the better of her, and insisted that I examine her to know if the retroflexion was cured. I unwillingly deceived her, and although I found the uterus just where it had doubtless been for years, managed to assure her that she need have no further fear of any uterine trouble. I was wrong in my estimate of this woman's disease, and should not now declare a retroflexion to have anything to do with the health of a patient past the menopause, if it were, as in this case, uncomplicated by other organic change. Dr. Bantock says, in his work on *Use and Abuse of Pessaries*, "No pessary yet invented can undo a flexion" (*loc cit.*). In this position, he is sustained by Hart and Barbour, beside other recent writers. I am fully confirmed in this view personally, but can endorse the evidence furnished by Dr. Bantock in the work above mentioned—although he does not pointedly allude to it—that pregnancy may happen while the pessary is worn, and in this way permanent cures not infrequently occur. In fact, the only cures I am aware of in my own experience have resulted in this way.

It is probable that the cases cured by pregnancy are those in which adhesive peritonitis has caused the malposition, and the gentle traction and pressure of the expanding uterus have caused the liberation of these retaining bands, while in the process of normal involution they do not reform. I will conclude this portion of my subject with this remark: I would use a pessary in the variety of displacement under consideration only as a temporary expedient, and never to the exclusion of frequent replacements or adjustment with a repositor, if necessary, and suitable position for the patient.

It is probable that some of the electricians may have treated these cases successfully, or that massage may prove satisfactory in the readjustment of versions and flexions, but I leave these methods to those having experience with them. I have elsewhere stated my great objection to the use of massage when, in our endeavor to do good, we may rupture a pus tube, and do infinite harm. (See *Gaillard's Journal*, November, 1889.)

The only pessary capable of supporting a retroflexed uterus is the intra-uterine stem. Great diversity of opinion prevails as to the propriety of using so dangerous an instrument. We may dislike their use, and fear bad results, but they give real support to the fundus, and there may be cases in which they can be used with signal benefit. I should prefer the intra-uterine stem to any of the proposed abdominal operations, such as suspension or fixation, provided the stem would sustain the body of the uterus, and that no other disease required abdominal section. Operative measures upon the neck of the uterus have been resorted to by Marion Sims and others, hoping to influence the position of the fundus, or at least to straighten the canal, but these have either failed to accomplish the intention of their inventor, or have not attracted general attention. Besides, they are not philosophically correct. The methods of surgical relief of posterior displacements are Alexander's operation, or shortening the round ligaments.

Ventro-fixation and Suspension; Operation upon the Broad and Round Ligaments Inside the Abdomen, and Shortening of the Utero-sacral Ligaments.

It is now evident that Alexander's operation has not been well received by the profession, and surgeons generally agree with

Winckel that it will soon become obsolete. It has been the experience of most surgeons to find the round ligaments unfit for service as a means of support, and other operations are generally required to assist in sustaining the uterus. The methods of suspension or fixation are now being tried by some surgeons, but I have space to mention only one case in my own practice:

Mrs. G., aged fifty years, came to me in 1888, suffering from retroflexion and prolapse of the uterus. She had worn pessaries for years, and was suffering from severe ulceration of the vagina as a result. I resorted to Alexander's operation after first amputating a very large cervix. The ligament was found on the left side, and secured as is usually done. That on the right was a mere thread, having undergone elongation until it was practically of no value. The incision in this case was extended upward and through the abdominal walls, until about three inches in length. The broad ligament and Fallopian tube, with the cornua of the uterus, was then stitched with catgut to the abdominal walls and within the lips of the wound. (Modification of Sänger's operation.) The woman has remained well of the malposition, although she is still a sufferer from neurasthenia.

Other cases of posterior displacement have occurred in practice requiring surgical treatment, but were generally brought to my notice for other reasons, notably in complication with diseased appendages.

One case worthy of mention was called lateroflexion. In the left side was found a hydrosalpinx, a large cystic ovary the size of an orange, and a band of adherent omentum two inches broad, fastening the tube to the ovary and broad ligament at its outer insertion to the pelvis. Another very interesting case was sent to me for Battey's operation. The uterus was fixed in the first degree of descent, the patient, a virgin, having been an invalid for many years, and having tried all sorts of treatment, including pessaries and dilatation of the uterus by a specialist (for what I have never learned). The adhesions suspected were found on the right side, holding down the uterus—a result of pelvic peritonitis. The appendages were removed, hoping to cure a menorrhagia and other symptoms, the right ovary looking like a beautiful cluster of grapes, from its cystic nature. The uterus was freely movable after the liberation of the adhesions, which was ascertained at the time of the operation, and it has since remained so; the patient is apparently well. These cases are not unfamiliar to those who do pelvic surgery, and could be greatly multiplied. I can endorse

the opinion, which I think was first suggested by Mr. Tait, that those cases requiring pelvic surgery for diseased appendages are thereafter cured of any preëxisting malposition. I prefer, so far as my own limited experience goes, to add the word "symptomatically."

Tait's operation of reefing the broad ligaments is therefore practical, and, moreover, not attended by additional danger, as the abdomen is generally opened in these cases for other disease than a mere displacement.

The same may be said of the measures advocated by Dr. Polk and others, who tie the broad and round ligaments in front of the uterus.

In addition to the operations already announced there are two methods which I have to suggest. The first, to sustain the lower segment of the uterus, and is a support to the utero-sacral ligaments. While the abdomen is open insert through the vagina both ends of a suture, an inch between, into and through Douglas's culde-sac. These sutures should be fastened to the round and broad ligaments, and can then be brought out separately two or more inches apart on the abdominal wall. By traction upon these ends the uterus and appendages are lifted well upward, and if denudation has been practised upon the superior and anterior wall of the uterus, there can be no doubt of the fixation being complete. This method has the advantage of holding the uterus and broad ligament entirely away from any raw surface made by the liberation of adhesions. It of course supposes an aseptic and well-packed vagina to prevent contamination from the uterus or lower vagina. The other plan proposed is to insert a double wire or other reliable material through the uterus and out at the fundus, a roll of gauze at either end of the suture, one to prevent the wire slipping into the uterine cavity, another on the abdomen to prevent cutting into the skin. This method is probably the same as that suggested by Dr. Sims, and mentioned by Dr. Emmet in 1889. (See *Trans. Amer. Gynecol. Soc.*, p. 267.) I have tried it on the cadaver, first placing the body in Trendelenburg's position. There was no transfixion of intestine. I should regard this the safest of all methods of suspension or fixation when the cavity of the abdomen is not to be opened. But it is beyond doubt safer to know just what one is doing, and hence there must indeed be but few cases

demanding these operations done in the dark. These operations last mentioned should be, as other methods of suspension, rarely resorted to, and only when they supplement other work.

Conclusions.—1. Displacements of the uterus backward may not give rise to symptoms, and do not require treatment unless other organs and tissues are involved.

2. If symptoms are present they are often due to neurasthenia, and demand appropriate treatment.

3. Those cases of posterior displacement which cause pain and give rise to dysmenorrhea and other symptoms, have generally a cause requiring other than mere treatment by pessaries, which is of temporary value only, and often prevents proper treatment of the real cause of disease.

4. Operations recently suggested, such as fixation, suspension, etc., are rarely required unless in connection with other operations, when the abdomen is open for other reasons, the treatment of which may set aside the necessity for the new methods.